Bureau of Health Care Quality & Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVS597S | A. BUILDING _____ B. WING _____ | C 07/24/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COLLEGE PARK REHABILITATION CENTER | 2856 E. CHEYENNE AVE. NORTH LAS VEGAS, NV 89030 |

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| Z 000 | Initial Comments<br><br>This Statement of Deficiencies was generated as a result of a complaint survey conducted at your facility on 7/23/08 and 7/24/08. The following complaints were investigated:<br><br>Complaints:<br><br>NV#18367- Substantiated (FTag 309)<br><br>NV #17724-Unsubstantiated<br><br>NV #18248-Unsubstantiated<br><br>NV #18438-Unsubstantiated<br><br>NV #18776-Substantiated (FTag 309)<br><br>NV #18347-Substantiated without deficiencies<br><br>NV #17871-Unsubstantiated<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.<br><br>The following regulatory deficiencies were identified: | Z 000 | | |
| Z230 SS=D | NAC 449.74469 Standards of Care<br><br>A facility for skilled nursing shall provide to each patient in the facility the services and treatment that are necessary to attain and maintain the patient's highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment conducted pursuant | Z230 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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| Z230 | Continued From page 1<br>to NAC 449.7443 and the plan of care developed pursuant to NAC 4493.74439.<br>This Regulation is not met as evidenced by:<br>Based on observation, interview, record review, and document review, the facility failed to ensure Resident #1 was transferred in a safe manner and failed to ensure policy and procedures were followed for the transfer of Resident #2, when she expired.<br><br>Findings include:<br><br>1) Resident #1<br><br>Resident #1 was a 61 year-old female who was admitted to the facility on 3/31/08 with diagnoses including Chronic Pulmonary Heart Disease, Venous Insufficiency, General Muscle Weakness, Iron Deficiency Anemia, and Abnormality of Gait.<br><br>Record Review and Document Review<br><br>Nursing notes revealed Resident #1 on 5/27/08, requested transfer assistance from the bed to the wheelchair to go to the bathroom. One male Certified Nursing Assistant (CNA) was assisting when the resident's knee buckled and she fell to the floor. The charge nurse (Staff #1) on duty called 911 for emergency medical personnel to lift the resident from the floor back to bed. The resident was sent to the hospital for an x-ray which revealed a broken fibula.<br><br>Record review revealed documentation dated 5/24/08, indicated the resident was to have a two person assist for transfers. The nurse's progress note dated 5/26/08 indicated maximum assist for transfers. The therapy notes documented the resident was high risk for falls. | Z230 | | |

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| Z230 | Continued From page 2<br><br>On 5/27/08, there were approximately nine employees on duty which was documented on the facility staffing schedule dated 5/27/08.<br><br>The nurse's progress note did not state how many CNAs assisted the resident and the reason a lift was not used to assist the resident back to her bed when staff and equipment were available to provide the necessary care for the resident.<br><br>Observation<br><br>During a tour conducted by the Director of Nurses on 7/24/08, there were two lifts observed in the facility capable of lifting individuals weighing 600 pounds, and one private lift rated for lifting a resident weighing 750 to 1000 pounds.<br><br>Interview<br><br>On 7/24/08 at 11:30am, Staff #1 (in charge of the 5/27/08, 10pm to 6:30am shift) stated that she thought the resident tried to transfer herself and fell. She stated that she wasn't aware of the lifts being able to hold the resident's weight. The resident weighed approximately 348 pounds. Staff #1 stated further that she thought the fire department emergency medical personnel were appropriate to contact to lift the resident back to the bed, stating, "I was told they do that, they do that in the community."<br><br>Interview with the family on 7/28/08, revealed that on 5/27/08, the night of the fall, there was only one CNA assisting the resident with the transfer.<br><br>CPT #18367<br><br>2) Resident #2 | Z230 | | |

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| Z230 | Continued From page 3<br><br>Resident #2 was admitted to the facility on 7/14/08, with diagnoses of UTI (Urinary Tract Infection), Dehydration, Bilateral Heel Decubitus Ulcer and Dehydration.<br><br>Record Review<br><br>On 7/21/08 at 8:30 PM, the nurse's notes indicated Resident #2 was found in bed with her eyes open, non verbal with no pulse or vital signs. The charge nurse was called in, 911 and the MD (medical doctor) was called and ordered a Code then Cardiopulmonary Resuscitation (CPR) was started. At 9:10 pm EMTs (fire department) arrived and continued CPR until 9:15 PM. The nursing notes indicated that the registered nurse (RN) pronounced demise at 9:30 PM. No family contact was available and at 1:10 am on 7/22/08, after calling the Director of Nursing and the Coroner's office, it was then determined the deceased body would be released to Desert Memorial (mortuary).<br><br>Interview<br><br>On 7/24/08, a telephone interview conducted with Staff #1, who was the charge nurse on 7/21/08 at night revealed:<br>- After EMTs arrived at the facility on 7/21/08, they took over CPR of Resident #2<br>- EMTs asked to obtain photo copies of the resident's record.<br>- Another situation arose and Staff #1 gave the photo copies to another nurse to give to EMTs.<br>- Staff #1 saw EMTs leave via the front door assuming they took Resident #2's body.<br>- An hour later a staff member asked Staff #1 what to do with the resident's body.<br>- Staff #1 thought EMTs would take the body and was not sure what to do. She was not sure who | Z230 | | |

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| Z230 | Continued From page 4<br>was to pronounce the resident and where the body was to go.<br>- Usually residents were "do-not-resuscitate" and may be pronounced dead, but since the EMTs did a full code, Staff #1 assumed it was their (EMTs) responsibility.<br>- The resident did not have a family or a pre-arranged destination for her body. Staff #1 then called the EMTs and asked what to do with the body. They referred her to the Coroner's office.<br><br>The facility staff was not aware of the policy and procedure of what to do with a deceased resident's body who was full code.<br><br>Document Review<br><br>The facility's policy and procedures indicated the charge nurse was the "code team leader" and was to provide detailed support to the advanced life support team (EMTs) and to answer any questions and assist with the smooth transfer of the resident. Staff #1 who was on duty the night of 7/21/08, failed to follow the facility's policy and procedures as the code team leader.<br><br>CPT #18776<br><br>Severity: 3 Scope: 1 | Z230 | | |